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PERSPECTIVE

The True Cost of Antitransgender Legislation

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Abstract

A large body of research finds that sexual and gender minorities experience disparities in health equity that stem from structural discrimination. In particular, transgender and gender diverse (TGD) patients face barriers in access to gender-affirming care (GAC). As of December 2021, 35 state legislatures have introduced >100 bills that categorically deny TGD individuals' human rights and outlaw medically necessary GAC. Importantly, the economic consequences of discriminatory legislation and denial of health care for TGD individuals are void in the literature. This perspective outlines the economic impact of antitransgender policy and calls for federal intervention to protect TGD rights.

Keywords: advocacy; antitransgender; cost; economic; policy

Introduction

As of December 2021, 35 state legislatures have introduced >100 bills that inhibit or categorically deny transgender and gender diverse (TGD) individuals' human rights and access to medically necessary gender-affirming care (GAC), including pubertal suppression therapy, hormone therapy, and gender-affirming surgery.

The Human Rights Campaign asserts that 2021 is a record-breaking year for antitransgender legislation.[1] Proposed state legislation includes criminal penalties for clinicians who provide GAC to prepubertal youth, banning TGD youth from participating in sports, restricting curricula on gender identity, and denying TGD individuals' access to public bathrooms.[1] The most devastating effects target TGD youth who already face a disproportionately higher risk of violence, victimization, substance use, and suicide.[2,3]

Approximately 5.6% of U.S. adults identify as lesbian, gay, bisexual, transgender, queer, intersex, and other sexual and gender-diverse identities (LGBTQI+), and 1.8% of adolescents identify as TGD.[3] In 2021, the Biden administration appointed the first openly transgender federal official to the position of assistant secretary of health. Despite increasing societal and federal acceptance of LGBTQI+ identities, state lawmakers have focused their efforts on antitransgender policy in the backdrop of a national pandemic.

Proponents of antitransgender legislation fail to ground themselves in the majority medical opinion and a large body of research demonstrating benefits of GAC for TGD health.[4] National medical associations including the American Medical Association and American Academy of Pediatrics oppose antitransgender legislation because it compromises the safety and well-being of our nation's youth and adult TGD populations.[5]

Importantly, the economic implications of antitransgender legislation are often underestimated. According to mandated fiscal impact statements, proponent state economists believe that the majority of antitransgender bills will have no significant economic costs. However, these analyses include only immediate considerations of state trial fees associated with litigation and ignore the long-term economic consequences of discriminatory legislation and untreated gender dysphoria.[6,7] Therefore, the fiscal impact of antitransgender legislation is not negligible, and states may experience economic benefits by adopting gender-affirming policies that reduce health disparities for TGD patients rather than denying them health care rights.

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Access to GAC Is Associated with Better Health Outcomes and Increased Health Care Utilization

TGD individuals face disparities in health equity and outcomes, generating avoidable costs associated with the treatment of preventable disease to medical systems and payers.[4,6] Structural discrimination, prejudice against certain populations that is enhanced by policy, creates barriers to routine health care and GAC for TGD patients. For instance, TGD youth experiencing dysphoria at the onset of masculinizing and feminizing phenotypic changes should have access to pubertal suppression (e.g., synthetic gonadotropin-releasing hormone analogues, GnRHa) therapy. TGD youth report psychological and physical benefits from therapy with GnRHa.[8,9]

Beyond pubertal suppression, masculinizing and feminizing hormone therapy can be used to alter hormone levels, creating both reversible and permanent physical changes to match an individual's gender identity. The long-term changes achieved through GAC help treat dysphoria and improve health outcomes for TGD patients. Under many of the proposed anti-transgender bills, physicians face criminal charges for offering potentially life-saving treatment to TGD youth.

Restricting access or outlawing pubertal suppression therapy is discriminatory against TGD youth, particularly since the same therapy has been used to treat central precocious puberty in cisyouth for decades.[10,11] Understandably, TGD patients may perceive these policies and the resulting negative experiences as discrimination by medical systems and forgo routine care or engage in potentially harmful health behaviors, perpetuating health disparities.[12]

An economic argument for increased access to GAC has been evaluated in the context of insurance policy. In 2016, Padula et al. found that the cost of not covering GAC for a transgender individual is $23,619 for a 10-year period, reflecting the medical costs of negative health outcomes including depression, substance use, and suicide.[7] Access to pubertal suppression and hormone therapy for TGD youth is inversely related to these negative health outcomes that manifest as additional costs to payers.[7]

Furthermore, addressing gender dysphoria early may reduce the need for higher risk and costly interventions later in life such as gender-affirming surgery for discordant sex characteristics. For example, without lengthening of the penis, individuals designated male at birth may experience less genital dysphoria and have less interest in surgery. Inclusive policy that covers GAC is cost-effective and aligns payers' financial interests. The upfront costs of GAC are offset by costly long-term adverse effects of excluded coverage.[3,7]

Cost Savings from Affirming Care Reinforces State Budgets

State budgets are similarly impacted by disparities in health outcomes for TGD patients. Mental health resources, substance use treatment, and certain insurance programs (e.g., Children's Health Insurance Program) require state funding. Addressing barriers to care for TGD patients may decrease the strain on these state-funded programs.[13] Structural and interpersonal discrimination against TGD individuals in clinical environments drive health disparities. For example, transgender men experiencing dysphoria about their reproductive organs may be less likely to present for routine gynecological care. Without routine screening and primary care, TGD communities experience poor health outcomes.

Compared with cisgender patients, TGD patients with cancer may be more likely to present at an advanced stage, have worse survival rates, and be less likely to receive treatment.[14] In addition to disparities in mental health outcomes, the cost of illness created by health disparities in the TGD population reflects an opportunity for cost savings. Inclusive policy that ensures access to GAC for TGD patients may even allow for greater allocation of state budgets toward improving general social services or education that benefit the overall population.

Because LGBTQI+ individuals comprise a significant portion of the population and labor force, discriminatory policies have economic consequences beyond costs to the health care system. Many of these consequences stem from negative experiences among TGD individuals in public spaces such as schools, creating disparities in educational outcomes associated with discrimination and minority stress.[3,4] Legislation restricting education on gender identity and banning TGD youth from gendered sports teams, which would otherwise affirm their identity, contribute to discrimination.

LGBTQI+ youth who experience discrimination are three times as likely to miss school, twice as likely to forgo postsecondary education (e.g., college), and have lower grade point averages than those who demonstrated positive school belonging.[15] Barriers to higher levels of educational attainment negatively affect investments in human capital and may lead to unemployment. State budgets gain revenue on taxable income, and LGBTQI+ individuals who experience discrimination in the workplace may yield less taxable income or file

for unemployment. In addition, higher rates of unemployment require larger payments from the state budget to support unemployment benefits, food assistance, and health insurance programs.[16]

Corporations Support LGBTQI+ Rights

Large corporations understand the productivity losses associated with workplace discrimination and many have chosen to invest in states with affirmative policy. These companies embrace the diversity of their employees, customers, and stakeholders, many of whom are LGBTQI+. For example, in 2016, North Carolina legislators passed legislation banning TGD individuals from using gender-affirming bathrooms. In response, PayPal ended plans to build a facility in the state for fear of discrimination against their employees.

Similarly, the National Collegiate Athletic Association became wary about hosting sporting events in the state. It was estimated that the "Bathroom Bill" would cost the state >$3.7 billion in gross domestic product and lost jobs.[17] A year later, once North Carolina legislators understood the economic repercussions, the bill was partially repealed, removing restrictions on bathroom use by TGD individuals.

Conclusion

Although justice and equity should drive lawmaking, antitransgender legislation appears to have negative economic consequences that are not represented in state fiscal analyses. Legal protections from discrimination are critical to achieving health equity for TGD patients and contribute positively to economic growth. In February 2021, the U.S. House of Representatives passed The Equality Act (HR 5), which prohibits discrimination based on sexual orientation and gender identity in employment, housing, public education, and public accommodations.[4]

Federal action against discrimination offers additional protections to TGD individuals and is likely to improve access to care especially in more politically conservative regions. Identifying the costs associated with antitransgender legislation may be an important conduit for change. Inclusive policy that affirms and supports TGD individuals is economically beneficial and reduces disparities in health equity. By considering the economic impacts of proposed legislation affecting the TGD community, lawmakers can make informed decisions about the health and well-being of the people they represent.

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References

1. Ronan W. BREAKING: 2021 becomes record year for anti-transgender legislation. Hum Rights Campaign. 2021;4047:1–8.
2. Park BC, Das RK, Drolet BC. Increasing criminalization of gender-affirming care for transgender youths—a politically motivated crisis. JAMA Pediatr. 2021;175:1205–1206.
3. Johns MM, Lowry R, Andrzejewski J, et al. Transgender identity and experiences of violence victimization, substance use, suicide risk, and sexual risk behaviors among high school students—19 states and large urban school districts, 2017. MMWR Morb Mortal Wkly Rep. 2019;68:67–71.
4. Gonzales G, Gavulic KA. The Equality Act is needed to advance health equity for lesbian, gay, bisexual, and transgender populations. Am J Public Health. 2020;110:801–802.
5. Kremen J, Williams C, Barrera EP, et al. Addressing legislation that restricts access to care for transgender youth. Pediatrics. 2021;147:e2021049940.
6. Gonzales G, Henning-Smith C. Barriers to care among transgender and gender nonconforming adults. Milbank Q. 2017;95:726–748.
7. Padula WV, Heru S, Campbell JD. Societal implications of health insurance coverage for medically necessary services in the U.S. transgender population: a cost-effectiveness analysis. J Gen Intern Med. 2016;31:394–401.
8. De Vries ALC, McGuire JK, Steensma TD, et al. Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics. 2014;134:696–704.
9. Costa R, Dunsford M, Skagerberg E, et al. Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. J Sex Med. 2015;12:2206–2214.
10. Lee PA, Klein K, Mauras N, et al. Efficacy and safety of leuprolide acetate 3-month depot 11.25 milligrams or 30 milligrams for the treatment of central precocious puberty. J Clin Endocrinol Metab. 2012;97:1572–1580.
11. Magiakou MA, Manousaki D, Papadaki M, et al. The efficacy and safety of gonadotropin-releasing hormone analog treatment in childhood and adolescence: a single center, long-term follow-up study. J Clin Endocrinol Metab. 2010;95:109–117.
12. Das RK, Gonzales G. Self-reported behaviors regarding medications to save money among sexual minority adults in the US, 2015-2018. JAMA. 2021;326:2526–2529.
13. Horwitz LI, Chang C, Arcilla HN, Knickman JR. Quantifying health systems' investment in social determinants of health, by sector, 2017–2019. Health Aff. 2020;39:192–198.
14. Jackson SS, Han X, Mao Z, et al. Cancer stage, treatment, and survival among transgender patients in the United States. 2021;113:1221–1227.
15. The 2019 National School Climate Survey. GLSEN, 2022. Available at: https://www.glsen.org/research/2019-national-school-climate-survey Accessed December 10, 2021.
16. Andersen TM, Svarer M. State dependent unemployment benefits. J Risk Insur. 2011;78:325–344.
17. Drew J. AP Exclusive: Price tag of North Carolina's LGBT law: $3.76B. 2021: 1–10. Available at: http://bigstory.ap.org/article/fa4528580f3e4a01bb68bcb272f1f0f8/ap-exclusive-bathroom-bill-cost-north-carolina-376b Accessed January 18, 2022.

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Abbreviations Used

GAC = gender-affirming care
GnRHa = gonadotropin-releasing hormone analogues
LGBTQI+ = lesbian, gay, bisexual, transgender, queer, intersex, and other sexual and gender-diverse identities
TGD = transgender and gender diverse